



**Public Health**  
Prevent. Promote. Protect.  
**Door County**

## Door County Public Health COVID-19 VACCINATION Screening and Consent Form

I have been given a copy and read or have had explained to me the information in the Emergency Use Authorization (EUA) of the applicable COVID-19 Vaccine to prevent Coronavirus disease 2019. I understand the benefits and risks of the COVID-19 vaccine and request that the immunization be given to me or the person named below for whom I am authorized to make this request.

I agree to inform vaccine staff if I have any questions or concerns.

I also understand that the information collected on this form will be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure continuation of health care services.

### Information of PERSON TO RECEIVE vaccine (Please Print Clearly)

Name	Gender	Date of Birth	Age
Mailing Address	City	State	Zip Code
Phone Number			

The following questions will help us determine if there is any reason we should not give you injectable COVID-19 vaccine today. If you answer yes, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked.

	Yes	No	
1. Are you currently in an isolation or quarantine period due to COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Have you received antibody therapy or convalescent plasma for COVID-19 treatment in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, date: _____			
4. Have you ever had a severe allergic reaction to any vaccine or injectable medication?	<input type="checkbox"/>	<input type="checkbox"/>	
a. If yes, list vaccine/medication and reaction: _____			
5. What dose of COVID vaccine are you receiving today (check one)	<b>Dose 1</b> <input type="checkbox"/>	<b>Dose 2</b> <input type="checkbox"/>	<b>Bivalent Booster</b> <input type="checkbox"/>
6. What vaccine did you previously receive? Pfizer Moderna Janssen (J&J)			
What date did you receive your most recent dose (last dose)? _____			

<b>SIGNATURE</b> X	<b>Date Signed</b>
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### Office Use Only

Vaccine	Route	Site	Manufacturer	Lot Number
COVID-19	IM	LD RD	Pfizer Moderna Janssen	

Signature and Title of Vaccine Administrator \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_